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No.03-6821

IN THE UNITED STATES SUPREME COURT

October Term, 2003

Supreme Court, U.S.
FILED
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DAVID LARRY NELSON,
Petitioner,

vs.

DONAL CAMPBELL,
Commissioner of the Alabama Department of Corrections,
and
GRANTT CULLIVER,
Warden of William C. Holman Correctional Facility,
Respondents.

ON PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

MOTION FOR LEAVE TO FILE BRIEF AND BRIEF OF AMICI CURIAE IN SUPPORT OF PETITIONER

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MOTION FOR LEAVE TO FILE AN AMICI CURIAE BRIEF PRIOR TO THE COURT'S CONSIDERATIN OF A PETITION FOR WRIT OF CERTIORARI

The amici curiae listed below, pursuant to Rule 37.2(b), Rules of the Supreme Court of the United States, move this Court for leave to file a brief in support of the above-captioned petition for a writ of certiorari.

BEST AVAILABLE COPY

In support, the amici curiae submit:

1. The above-styled petition for a writ of certiorari was timely filed. Petitioner is indigent and has been permitted to proceed in forma pauperis in all prior proceedings.

2. The above-styled petition centers around medical procedures contemplated by the Respondents to be performed on the Petitioner to gain venous access to the Petitioner so that he may be executed by lethal injection. The medical procedures being contemplated by the Respondents are complicated medical procedures that will involve significant risk to the Petitioner and should be performed only by highly specialized, credentialed medical personnel.

3. From the limited information volunteered by the Respondents throughout litigation of this matter, it appears that no competent, credentialed physician is overseeing the Respondents' plan to gain venous access to the Petitioner. Furthermore, it is unknown what experience and credentials the medical personnel who will be employed by the Respondents to perform the medical procedures possess.

4. The amici curiae are all practicing physicians in the State of Alabama who have reviewed the Respondents' proposed plan to gain venous access in the Petitioner. The amici curiae, with their medical training and knowledge, can offer a unique perspective to the Petitioner's case and can explain to the Court the medical concerns raised by the Respondent's proposed medical procedures.

5. The amici curiae are in a position to raise matters that neither of the parties can raise given their responsibilities as advocates and their lack of medical training.

6. The amici curiae offer the attached brief in support of the Petitioner's Petition for Writ of Certiorari. The amici curiae received authorization from the Petitioner's counsel to file the attached brief. Counsel for the Respondent refused to consent to the filing of a brief by amici curiae.

ACCORDINGLY, the amici curiae move this Court for leave to file the attached brief in support of this Court's consideration of Petitioner David Nelson's Petition for Writ of Certiorari.

Respectfully Submitted,

Kathryn L Lippert

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Counsel for Amici Curiae

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CERTIFICATE OF SERVICE

QUESTIONS PRESENTED

The Petitioner has raised the following two questions in his Petition for Writ of Certiorari before this Court:

1. Whether an action brought by a death-sentenced prisoner pursuant to 42 U.S.C. § 1983, which does not attack a conviction or sentence, is – simply because the person is under a sentence of death – to be treated as a habeas corpus case subject to the restriction on successive petitions which categorically precludes review of *any* constitutional violation not related to innocence (as the Fourth, Fifth and Eleventh Circuits hold), or can be maintained as § 1983 action (as the Sixth, Eighth and Ninth Circuits and several lower courts hold)?

2. Whether a cut-down procedure, which involves pain and mutilation, conducted prior to an execution by lethal injection, violates the Eighth Amendment to the United States Constitution?

STATEMENT OF INTEREST OF AMICI CURIAE

Each amicus curiae is a practicing physician in the State of Alabama[1]. The amici curiae have been informed of the medical procedures the Respondents have proposed using to gain venous access to the Petitioner to execute him by lethal injection.

The proposed medical procedures concern us as physicians for a number of reasons. First, obtaining central venous access is a complex medical procedure that involves serious risks and should only be performed by properly trained personnel. In this situation the Respondents will not disclose the credentials of the people who will be performing the procedure, including whether or not the physician is actually licensed to practice medicine in the State of Alabama or any other state. We are also concerned because it is apparent to us that the Respondents hope to implement a plan that was not designed by competent, credentialed physicians, and thereby are placing the Petitioner at high risk of enduring severe and needless pain and suffering.

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1 Pursuant to Rule 37.6, Rules of the Supreme Court of the United States, counsel for neither party has authored this brief in whole or in part.

SUMMARY OF ARGUMENT

The Respondents must gain venous access to the Petitioner in order to execute him by lethal injection. Venous access may be obtained in most people by placing a very thin catheter under the skin in the hand or arm. Gaining venous access in this manner is referred to as peripheral venous access and is a relatively simple procedure.

Gaining peripheral venous access may be difficult or essentially impossible in some patients. When dealing with these people, central venous access must be obtained, which involves obtaining access to a central vein such as those in the chest and abdomen. Central venous access can only be achieved via a relatively complicated medical procedure.

The Respondents have essentially conceded that they will not be able to gain peripheral venous access to the Petitioner in order to execute him by lethal injection. As such, they will have to perform an invasive medical procedure to gain central venous access to the Petitioner prior to his execution.

There are two predominant methods for obtaining central venous access - - the percutaneous technique and the cut down

technique. In the overwhelming majority of situations where central venous access is required, the percutaneous technique is heavily favored over the cut down technique. This is because the percutaneous technique is less invasive, less painful, safer, faster, easier to learn, easier to teach, and easier to perform.

Attempts to gain central venous access should only be made by skilled, experienced physicians who have been specially trained to perform the requisite medical procedures. It cannot be emphasized enough that merely being a physician in no way qualifies a person to perform medical procedures to gain central venous access.

Many serious and painful complications may arise while a central venous catheter is being placed. These complications include severe pain, hemorrhage (severe bleeding), serious cardiac arrhythmias (abnormal beating of the heart causing shock), and pneumothorax (lung collapse due to collection of air between the lung and chest wall). Additionally, the amount of pain caused by the procedure is related to the experience of the medical practitioner performing the procedure.

For some unknown reason, the Respondents intend to use the cut down procedure instead of the percutaneous procedure. The Respondents also refuse to disclose the credentials and experience of the medical personnel who will be in charge of performing the cut down procedure.

Based on the scant information that the Respondents have disclosed, it appears that people with sufficient medical knowledge have not designed the medical procedure being prepared by the Respondents. Furthermore, there are no assurances that a competent, qualified, licensed physician will be performing the medical procedures proposed by the Respondents.

Of no small concern is the fact that the proposed medical procedures described by the Respondents include references to anatomy not present in human beings. In addition, the Respondents use the terms "percutaneous technique" and "cut down technique" interchangeably when the techniques are completely distinct.

Based upon the foregoing, the amici curiae have grave concerns about the medical procedures proposed by the Respondents. The amici curiae strongly recommend that the Petitioner's execution

be postponed until the Respondents disclose a medically sound, detailed description of the procedure that will be undertaken as well as a description of the experience and credentials of the medical personnel who will be performing the procedure.

ARGUMENT

I. INTRODUCTION

The Respondents have encountered a unique problem in the Petitioner's case involving the need for medical procedures to be performed on the Petitioner in order for the Respondents to gain intravenous access to the Petitioner for the purpose of executing him by lethal injection. It the intent of the amici curiae to outline some of the considerations surrounding intravenous access and also to explain the bases for our concerns about the medical procedures for gaining intravenous access to the Petitioner which are being contemplated by the Respondents.

II. BASIC CONSIDERATIONS REGARDING INTRAVENOUS ACCESS

Obtaining intravenous access is a common and essential procedure in the contemporary practice of medicine, because many drugs are only effective if delivered directly into the venous system.

In the vast majority of situations, intravenous access can be easily obtained by placing a very thin catheter (the same diameter or smaller than the wire of a coat hanger) into a vein located just under the skin in the hand or arm. This is called "peripheral access", as contrasted with "central access" which makes use of a "central vein" such as those in the chest and abdomen. Peripheral access is usually a minor procedure that causes a small amount of pain or discomfort, comparable to that caused by a vaccination.

Unfortunately, in some patients peripheral access cannot easily be obtained, or is essentially impossible to obtain. One circumstance where this problem is commonly encountered is in patients who have received chemotherapy, which causes injury and scarring of peripheral subcutaneous veins. As their veins deteriorate, a point is reached where the search for peripheral access becomes arduous and agonizing, and the patient and physician reach a joint decision to place a central intravenous catheter. This decision is not reached lightly, as placement of a chronic indwelling central catheter is a non-trivial surgical procedure that involves pain and risk. Often the patient is referred to a physician with expertise in obtaining vascular access; as

many physicians do not themselves have the experience and credentials to place a central catheter or to treat the complications that are associated with the procedure. Other clinical situations that involve difficult intravenous access include obese patients (in whom the subcutaneous veins are obscured by adipose tissue), patients who have taken corticosteroids for diseases such as arthritis and lupus, patients who suffer from diabetes and regularly inject insulin, and patients with a history of intravenous drug abuse. Additionally, some patients without any apparent reason just have no readily accessible peripheral veins.

Central venous access is indicated in several other clinical situations. As an example, patients undergoing major surgery often undergo central line placement (usually after general anesthesia has been induced) for the purposes of delivering large volumes of blood and fluids to treat anticipated intraoperative bleeding. Patients undergoing cardiac catheterizaton for diagnostic purposes may also require the placement of central venous catheters. Central access is also required for the placement of implanted cardiac pacemakers. The above list is not intended to be comprehensive, but rather is presented

for the purpose of conveying the scope of settings in which central intravenous access may be required.

It should be noted that in the great majority of the above-referenced therapeutic situations, peripheral intravenous access is obtained prior to embarking on the central venous access procedure. This allows the practitioner to administer painkillers and sedatives which render the central venous access procedure virtually innocuous. In the rare and unfortunate situation where peripheral intravenous access cannot be established before placing the central line, the experience is physically grueling, painful, and arduous for the person undergoing the procedure.

III. TECHNIQUES FOR OBTAINING CENTRAL VENOUS ACCESS

Putting aside rarely used methods, it is fair to say that two main techniques are used for obtaining central venous access. One technique, which is the most commonly used today, is called the "percutaneous technique". This involves inserting a needle through the skin and into the vein, then passing a thin wire through the lumen of the needle, then removing the needle over the wire to leave the wire placed in the vein, and then finally advancing a thin flexible catheter

over the wire into the vein. The wire can then be removed, leaving the catheter in the vein. Usually this procedure is performed in the groin (femoral vein), the neck (internal or external jugular vein), or under the collar bone (subclavian vein).

The second technique for obtaining central intravenous access is called the cut down technique. This involves the use of a scalpel to make a series of incisions through the skin, the subcutaneous fat, and the underlying muscle, to reach the relatively deeply located central vein. The length of these incisions is in the range of two inches and depends upon a variety of factors including location of the incision, degree of scarring, depth of the vessel, and the skill of the surgeon. As with the percutaneous technique, this procedure is usually performed in the groin (femoral vein), the neck (internal or external jugular vein), or under the collar bone (subclavian vein). The cut down technique is also used to obtain access to veins in the arm and leg, particularly in the setting of shock from trauma, where bleeding has emptied the vascular system and percutaneous access is thereby made difficult. Unlike the percutaneous technique, the cut down technique requires an array of surgical tools including hemostats, retractors, scissors, and

scalpels. The procedure typically requires the use of electrocautery, which is used to stop bleeding by burning the open ends of blood vessels.

The selection between these techniques is a therapeutic decision that is made by the practitioner based on the considerations of the individual situation. Nevertheless, we state with confidence that in the overwhelming majority of situations where central access is required, the percutaneous technique is heavily favored over the cut down procedure. The reasons for this are simple: compared with the cut down technique, the percutaneous technique is less invasive, less painful, less expensive, safer, faster, easier to learn, easier to teach, and easier to perform.

IV. QUALIFICATIONS FOR OBTAINING CENTRAL ACCESS

Obtaining central venous access, whether by the percutaneous technique or the cut down technique, is a significant medical procedure that requires skill, judgment, and experience. These procedures are typically taught during post-graduate medical residency training, and involve "elbow to elbow" supervision by an experienced practitioner. Some medical specialties (including surgery,

anesthesiology, cardiology, intensive care, and interventional radiology) frequently involve placement of central venous catheters. In other medical specialties, it is frequently the case that a patient requiring central venous access will be referred to a physician with expertise and proficiency in performing the procedure.

For physicians to be permitted to practice in a given hospital, they must apply for and receive admitting privileges. As part of this process, a physician will apply for permission to perform various procedures, and hospitals have in place systems for ascertaining whether such procedure privileges should be granted. Obtaining central venous access, whether by the percutaneous technique or the cut down technique, is a procedure that is specifically privileged by hospitals. This system is followed throughout the country as a means of ensuring that personnel possessing adequate training and experience care for patients. In particular, in granting privileges for performing central venous access a hospital board would need evidence that a physician performs the procedure with significant frequency and has appropriate credentials. Among the required credentials would be evidence of active state licensure. A hospital would also need to

review a physician's career record to ensure that there was no history of licensure revocation for misconduct or incompetence. It is very important to understand that merely being a physician in no way provides an assurance that proficiency or even familiarity with intravenous access exists.

V. COMPLICATIONS OF PLACING CENTRAL VENOUS CATHETERS

One of the reasons for requiring credentialing for obtaining central venous access is that the procedures are associated with significant complications. These complications include pain, hemorrhage (severe bleeding), cardiac arrhythmias, and pneumothorax (accumulation of air in the space between the lung and inner chest wall, causing lung collapse and suffocation). The amount of pain caused by the procedure is related to the experience of the practitioner. A skilled practitioner will spend less time "fishing around" to find the location of the vein and will be more adept at effectively infiltrating local anesthesia to make the procedure more comfortable.

Hemorrhage can occur because of lacerating or rupturing the large blood vessels that are the targets of the procedure. Hemorrhage can be external or internal. If it is external, one result can be

widespread distribution of blood throughout the operative field, including the drapes covering the patient's face, the floor, the medical personnel, and the operating table. If the hemorrhage is internal, expertise and experience is often required to recognize the problem and provide appropriate treatment. Hemorrhage, while not painful per se, is extraordinarily distressing and is associated with nausea, shortness of breath, a sense of suffocation, and terror.

Cardiac arrhythmias (abnormal beating of the heart) can be triggered by inadvertent stimulation of the heart muscle by the catheter or wire. These arrhythmias can cause a profound lowering of blood pressure, which like hemorrhage is extremely distressing. If that were to occur, the patient would likely require electrical defribrillation or electrical cardioversion, both of which would burn the skin and produce an extraordinarily agonizing experience for a conscious patient.

Finally, the complication of pneumothorax can be caused by inadvertently puncturing the thin sac that separates the lungs from the inner side of the chest wall. The resulting lung collapse is painful and extremely distressing, causing suffocation and sometimes death. The

treatment of pneumothorax involves the insertion of one or more large diameter tubes (approximately one-half inch in diameter) between the ribs and deep into the chest to evacuate the air. This procedure is painful, should only be performed by experienced practitioners, and is accompanied by its own set of catastrophic complications.

It should be noted that in most clinical situations in which central venous access is being obtained, peripheral intravenous access has already been established. Peripheral lines play a critical role in the treatment of the above-described complications because they permit the administration of painkillers and sedatives, drugs for treating arrhythmias, and allow for the infusion of blood and other fluids to treat hemorrhage. Logically, in a setting where central access is required because peripheral access could not be achieved, these complications are much more fearsome and difficult to manage.

VI. CONCERNS OF AMICI CURIAE REGARDING THE STATE OF ALABAMA'S PROPOSED PROCEDURES TO OBTAIN CENTRAL VENOUS ACCESS IN THE PETITIONER

It is our understanding that the Petitioner has a history of difficult intravenous access. The affidavit of Warden Grantt Culliver states that difficulty is anticipated in obtaining intravenous access and

that a plan has been formulated to obtain central venous access. It is our further understanding that this plan involves attempting catheter placement in the groin, the neck, or the arm.

It is our understanding that the Respondents have refused to disclose the State of Alabama's protocol for lethal injection and have disclosed very little information about the methods that will be employed in attempts to gain venous access in the Petitioner. It is our further understanding that the Respondents have not disclosed any information about the personnel who will be placing the central catheter in the Petitioner, including information about the personnel's credentials and experience. Indeed, it is not even known whether the individual who will be performing the medical procedure holds a current license to practice medicine in the State of Alabama or any other state. Thus, there is no assurance or basis for confidence that a suitably proficient practitioner will perform the medical procedure.

The failure on the part of the Respondents to provide this information makes it impossible to rationally ascertain whether or not reasonable steps have been taken to ensure that the procedure will not be bungled and cause extreme suffering and distress to the Petitioner.

Warden Culliver in his affidavit states that if the central intravenous access is obtained via the neck, the "external carotid vein" will be used. There is no such structure in human beings, and it is not credible to the amici curiae that a trained physician or practitioner would even mistakenly use this term. Oddly, an affidavit by Dr. Marc Sonnier also uses the term "external carotid vein". The use of this term bespeaks the presence of less than a glimmer of familiarity with the procedure and buttresses our concern that the personnel recruited by the Respondents for this procedure will not possess the requisite proficiency and expertise. It is difficult to believe that any personnel currently employed by the Respondents possess the requisite expertise to perform, review, or "sign off" on the procedures proposed by the Respondents.

It is our understanding that Warden Culliver's initial plan was to place the central line twenty-four hours in advance of the execution. This plan reflects a troubling lack of judgment. The fact that Warden Culliver retracted this ill-advised plan, eventually asserting that the procedure would be performed one or two hours prior to the execution, does nothing to mitigate the fact that he made the proposal and, for a

period of time, defended it. Also, it is our understanding that Warden Culliver initially informed the Petitioner that the procedure would involve an incision a quarter of an inch in length but later informed the Petitioner, as is reflected in his affidavit, that the incision would be approximately two inches in length. Warden Culliver clearly lacks the experience and expertise to make decisions about the medical features of the procedure.

It is also our understanding that during early discussions about plans to obtain intravenous access in the Petitioner, Warden Culliver used the term "cut-down" to refer to the percutaneous procedure. As described above, the two procedures are very different, and in virtually all cases it is preferable to use the percutaneous technique. Warden Culliver's failure to discern the distinctions between these procedures, in conjunction with his apparent prominent role in designing the procedure, strongly suggests that the Petitioner is at risk for being subjected to a poorly designed procedure.

In summary, the procedures for obtaining central venous access are complex medical procedures that require training and skill and should only be performed by experienced and credentialed personnel.

Warden Culliver's approach thus far has been to conceal from the Petiitoner the nature of the procedure to be performed and the qualifications of the personnel who will be performing it. Based upon the scant information that has been provided by the Respondents, the amici curiae are concerned that the Petitioner is at great risk of experiencing unnecessary suffering and pain.

VII. CONCLUSION

In view of the above-described problems, each amicus curiae cannot escape the unfortunate conclusion that the Respondents have taken a haphazard and disarrayed approach to designing the procedure for obtaining intravenous access in the Petitioner's case. This situation brings to mind an adage of medical training, "failing to plan is planning to fail". We do not understand why it would not be in the best interest of the Respondents to contract with a demonstrably experienced physician to perform the procedure of obtaining central intravenous access on the Petitioner. We also do not understand why it would not be in the best interest of the Respondents to provide information about the physician's credentials so that it could be reasonably determined that central intravenous access would be

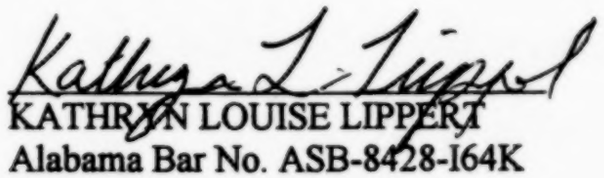
obtained in a fashion that would minimize the risk of needless cruelty, pain, and suffering.

It is our understanding the need to obtain central venous access in the Petitioner is not emergent. The readily apparent lack of a coherent program for designing and carrying out this procedure on the Petitioner leads us to recommend in the strongest possible terms that the procedure be postponed until the elements set forth above are brought into place. Specifically, we recommend that the Respondents be required to disclose a reasonably detailed and medically sound description of the procedure to be undertaken and a detailed description of the personnel who will be performing the procedure, including the credentials of the medical personnel. We, of course, recognize the medical personnel's desire for anonymity in the context of performing medical procedures related to an execution. However, it is not difficult to envision a solution that allows for a review of this information without revealing the identity of the specific personnel. For example, a mutually agreed upon independent party could review the professional credentials and licensure of the medical personnel and provide an assurance to interested parties that appropriately

credentialed personnel would be involved.

The amici curiae respectfully request that this Court grant the Petitioner's Petition for Writ of Certiorari.

Respectfully submitted,



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CERTIFICATE OF SERVICE

I hereby certify that I have this date served a true and correct copy of this Brief of Amici Curiae in Support of Petitioner by United States Mail with proper postage affixed thereto upon the following:

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